Select Health of the Twin Cities

Disc • Neuropathy • Pain & Regenerative Care • Laser

Disc/Spine Patient Intake

We are excited you have chosen us to assist you with your disc condition. Please fill out the information below as completely as possible so the Doctor(s) may properly evaluate you. If you need assistance, please ask the front desk!

Confidential Patient Information

PLEASE PRINT LEGIBLY

Legal Name_____ Name you prefer to be called _____

Address_____City _____State_____ Zip_____

Cell Phone _____ Email _____

Birth Date_____ Age_____ Male ☐ Female ☐

Occupation_____ Employer _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated

Emergency Contact _____ Phone # _____

How did you become aware of our clinic?

☐ Referral from Patient?-→ Patient Name: _____ ☐ Referral from Doctor? Name: _____

☐ Google ☐ Facebook ☐ TV – Channel? _____ ☐ Radio – Station?_____

☐ Newspaper ☐ Billboard ☐ Seminar

How long has your condition been affecting you? _____

Please answer the following depending on your condition (note: not all may apply)

Check your DISC/SPINE condition

☐ Herniated Disc
☐ Bulging Disc
☐ Degenerative Disc
☐ Stenosis
☐ Sciatica
☐ Neck Pain
☐ Low Back Pain
☐ Scoliosis
☐ Other:_____

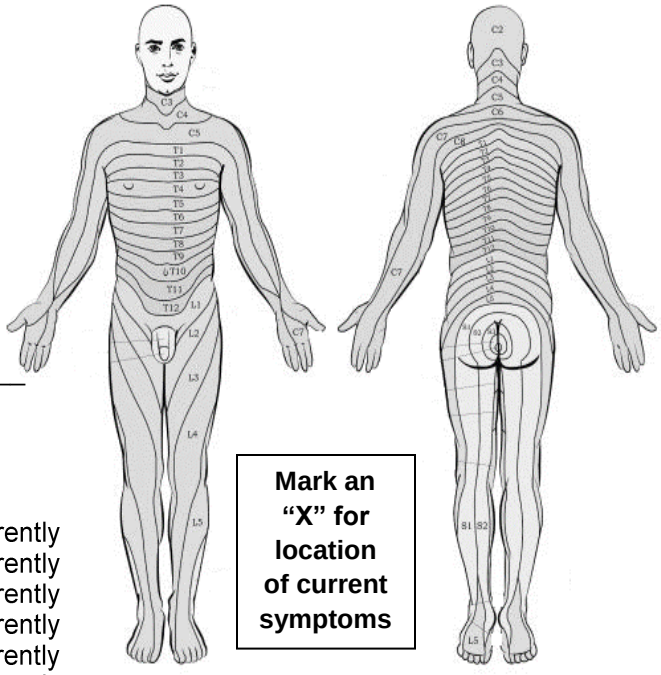
Cause of Condition

☐ Trauma
☐ Car/Work Accident
☐ Repetitive Stress
☐ Toxins
☐ Surgery
☐ Idiopathic / Not sure
☐ Other:_____

For all questions listed, please check all boxes that apply

1. Please rate your condition on average as: ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

2. Is your pain/symptoms: ☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Crushing ☐ Stabbing ☐ Burning ☐ Cramping ☐Pins and Needles ☐ Heavy feeling ☐ Hot Sensation ☐ Cold Sensation ☐ Swelling ☐ Electric shocks ☐ Numbness ☐ Tightness ☐ Stiffness ☐ Tingling ☐ Weakness ☐ Other _____



Mark an "X" for location of current symptoms

Treatments You Have Tried For This Condition

Medications	☐ YES	☐ NO	☐ Past	☐ Currently
Exercise/Stretching	☐ YES	☐ NO	☐ Past	☐ Currently
Physical Therapy	☐ YES	☐ NO	☐ Past	☐ Currently
Chiropractic	☐ YES	☐ NO	☐ Past	☐ Currently
Massage/Other	☐ YES	☐ NO	☐ Past	☐ Currently
Injections	☐ YES	☐ NO	☐ Past	☐ Currently
Creams	☐ YES	☐ NO	☐ Past	☐ Currently

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Current Pain Levels:

How would you rate your pain/symptoms on average in the last month?

NO PAIN/SYMPTOMS 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

If you had to accept some level of pain/symptoms after completion of treatment, what would be an acceptable level?

NO PAIN/SYMPTOMS 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

If your symptoms radiate, where do they radiate to: (mark all that apply) (R= Right, L= Left)

☐ Buttock: R or L ☐ Groin: R or L ☐ Thigh: R or L ☐ Knee: R or L ☐Lower Leg: R or L
☐ Ankle: R or L ☐ Foot: R or L ☐ Big Toe: R or L ☐ Shoulder: R or L ☐ Arm: R or L
☐ Hand: R or L ☐ Wrist: R or L ☐ Fingers R or L

Are your symptoms: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional ☐ Infrequent

Are your symptoms: ☐ Getting Better ☐ Getting Worse ☐ Staying the Same

Are your symptoms worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ At Night/While Sleeping ☐ All the same

Do any of these relieve the pain / problem: ☐ Heat ☐ Ice ☐ Stretching ☐ Pain Meds ☐ Rest ☐ Nothing Helps
☐ Other _____

If you are currently taking medications, please circle the appropriate medication, if any:

Gabapentin (Neurontin) Lyrica Oxycodone Percocet Aleve Tylenol Ibuprofen

List allergies, including any medications or nutritional supplements: _____

Any Secondary Conditions?

Please check all that apply

☐ Diabetes ☐ Surgery ☐ High Blood Pressure ☐ Poor Wound Healing
☐ Knee Pain ☐ Cancer ☐ Chemotherapy ☐ Joint Replacement
☐ Shoulder Pain ☐ High Cholesterol ☐ Vascular Problems ☐ Arthritis
☐ Weight Gain ☐ Autoimmune Condition ☐Knee Pain ☐ Other:_____

Risk Factor Questions

Do you have a pacemaker? (please circle one):	**YES**	**NO**
Do you have any recent spine fractures? (please circle one):	**YES**	**NO**
Have you been diagnosed with an abdominal aneurism (please circle one):	**YES**	**NO**
History of bone cancer / infection / disease/ disorder (please circle one):	**YES**	**NO**

Medication and Surgical History

Surgery			
	Yes	No	Year
Tonsils			
Colon			
Hernia			
Appendix			
Gall Bladder			
Heart			
Kidney			
Breast			
Uterus			
Ovaries			
Prostate			

Have You Ever Taken			
	Yes	No	Year
Insulin			
Cortisone			
Thyroid Medication			
Male/Female Hormones			
Blood Pressure Medication			
Cholesterol Medication			
Anti-Depressants			
Tranquilizers / Sedatives			
Birth Control			

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Injections/ Surgery

Have you had any injections or epidurals for your condition? (please circle one): **YES** **NO**

If yes: How many? _____ When? _____

Have you been told you need any injections? (please circle one): **YES** **NO**

Have you had surgery for your conditions? (please circle one): **YES** **NO**

Have you been told you need surgery? (please circle one): **YES** **NO**

If yes: By whom? _____

Family History

Please indicate if anyone in your family has, or has in the past, suffered from any of the following conditions

☐ Arthritis	Whom? _____	☐ Back Pain	Whom? _____
☐ High Cholesterol	Whom? _____	☐ High Blood Pressure	Whom? _____
☐ Cancer	Whom? _____	☐ Osteoporosis	Whom? _____
☐ Diabetes	Whom? _____	☐ Stroke	Whom? _____
☐ Heart Disease	Whom? _____	☐ Thyroid Conditions	Whom? _____

Patient History

Condition	Past	Present	Condition	Past	Present	Condition	Past	Present
Angina/Chest Pain			Headaches			Night Sweats		
Arthritis			Heart Problems			Numbness		
Asthma			HIV			Paralysis		
Balance Problems			Irritability			Seizures		
Broken Bones			Joint Stiffness			Sleeping Problems		
Cancer			Joint Swelling			Scoliosis		
Chills			Joint Tenderness			Stiffness		
Concentration Loss			Loss of Sleep			Stroke / TIA		
Diabetes			Lumps			Tingling		
Dizziness			Masses			Thyroid Problems		
Fatigue			Memory Loss			Tremors		
Fainting			Muscle Cramps			Vertigo		
Fever			Muscle Pain			Weakness		
Gout			Nervousness			Other Please List:		

Social History

1. Smoking: (usage) ☐ Cigars ☐ Pipe ☐ Cigarettes — How Often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverages: (consumption) — ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug Use: — ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. Hobbies/ Exercise Regimen:

How does your present problem affect? (**See next page**)

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Activities of Life:

Please indicate how your neuropathy is affecting your ability to carry out activities that are routinely part of your life:

Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Doing Computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
House Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Other_____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform

Other Physician Information

Primary Doctor: _____ Phone #:_____

Specialists: _____ Phone #:_____

May we send them updates on your treatment / condition? ☐ Yes ☐ No

I attest that all the information provided is true and accurate to the best of my ability

_____ _____

Print Name Date

_____

Sign Name

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Quality of Life Survey

TODAY'S DATE: _____ / _____ / _____

These questions are so the Doctor can evaluate how your health condition is affecting your quality of life and what your goals regarding treatment might be. Please fill them out as accurately and descriptively as possible so we are able to best help you heal!

1. What do you desire MOST to get out of treatment in our office?

_____

_____

_____

2. What is your biggest concern about this health condition?

_____

_____

_____

3. If this problem does NOT improve, where do you picture yourself being in the next 1-3 years?

_____

_____

_____

4. What might be better in your life without this condition? Please be specific:

_____

_____

_____

CIRCLE AS MANY AS APPLY:

5. What has been the result of the previous care for your health condition?

a. Bad results
b. Some results
c. Great results
d. Nothing changed
e. Did not get worse
f. Did not help for very long

6. What are you thinking this might be already (or beginning) affecting (or will affect)?

a. Job
b. Kids
c. Future ability
d. Marriage
e. Self-esteem
f. Sleep
g. Time
h. Finances
i. Freedom

7. Are there health conditions you are thinking this condition might turn into (or might happen)?

a. Heart disease
b. Diabetes
c. Arthritis
d. Fibromyalgia
e. Depression
f. Chronic Fatigue
g. Need surgery

8. How much has your health condition affected:

0=Has not affected at all 10=Extremely affected

Job:	0	1	2	3	4	5	6	7	8	9	10
Relationships:	0	1	2	3	4	5	6	7	8	9	10
Finances:	0	1	2	3	4	5	6	7	8	9	10
Family:	0	1	2	3	4	5	6	7	8	9	10
Other Activities:	0	1	2	3	4	5	6	7	8	9	10

9. As a result of your health condition affecting your job, lifestyle, family, etc. Please rate how much it has impacted the following:

0=No impact at all 10=Extreme amount of impact

Time:	0	1	2	3	4	5	6	7	8	9	10
Happiness:	0	1	2	3	4	5	6	7	8	9	10
Freedom:	0	1	2	3	4	5	6	7	8	9	10
Sleep:	0	1	2	3	4	5	6	7	8	9	10
Overall Lifestyle:	0	1	2	3	4	5	6	7	8	9	10

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Informed Consent and HIPAA / Privacy Practices

INFORMED CONSENT I hereby request and consent to the performance of: physical examinations and evaluations and performance of any tests required to be performed to diagnose my condition(s), and for treatment, including various modes of physical and rehabilitation therapy, disc specific treatment, or peripheral neuropathy treatment, which the doctor will explain to me, and of other procedures on me (or on the patient named below, for whom I am legally responsible) by or under the supervision of the doctor named below, or by trained clinic staff, or other licensed doctors who now or in the future treat me while employed by, working, or associated with, or serving as back-up for the doctor named below, including those working at the clinic or office listed below or any other office or clinic.

I have had, or will when questions arise, take the opportunity to discuss with the doctor named below and/or with other office or clinic personnel, the nature and purpose of all procedures. I understand that results cannot be guaranteed. I understand and am informed that, as in any healthcare practice, there are some rare risks to treatment, including, but not limited to: no results, fractures, disc or spine injuries, strokes, dislocations and sprains.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the treatments which the doctor recommends at the time, based upon the facts then known, and is in my best interests.

I have read, or had read to me, the above consent. I have also had an opportunity, or will take the opportunity, to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present conditions(s) and for any future condition(s) for which I seek treatment.

HIPAA. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting at the front desk.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

By my signature below, I acknowledge I have had the opportunity to review the Notice of Privacy Practices located at the front desk.

To be completed by patient:

_____
Patient's Name

_____
Signature of Patient

_____
Date Signed

To be completed by patient's representative, If necessary,
e.g., if patient is a minor or is physically or mentally incapacitated

_____
Print Patient's Name

_____
Print Name of Patient's Representative

_____ ____ / ____ / ____
Signature of Patient' Representative & Date Signed

_____
Relationship of Authority of Patient's Representative

_____/_____
(Name and relationship) has permission to receive information regarding my records.

_____/_____
If applicable - Translated by

_____/_____
Witness to Patient's Signature Date

Print name(s) of primary doctor(s) treating this patient:

Dr. Jamy Antoine, D.C and/or Dr. Daniel Piper, D.C